Non-Emergent Hyperbaric Oxygen Therapy Prior Authorization Model

Frequently Asked Questions

1. **What is prior authorization?**

   Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure that applicable coverage, payment and coding rules are met before services are rendered. Some insurance companies, such as TRICARE, certain Medicaid programs, and the private sector, already use prior authorization to help ensure proper payment before the service is rendered.

2. **Does prior authorization create new documentation requirements?**

   Prior authorization does not create new documentation requirements. Prior authorization would simply require currently mandated documentation earlier in the claims payment process.

3. **What does the prior authorization model do?**

   The model establishes a prior authorization process for hyperbaric oxygen therapy for certain covered conditions to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care.

4. **When does the Non-Emergent Hyperbaric Oxygen Therapy Prior Authorization Model begin?**

   Facilities and beneficiaries began submitting prior authorization requests in Michigan on March 1, 2015 for treatments occurring on or after April 13, 2015.

   Facilities and beneficiaries may begin submitting prior authorization requests in Illinois and New Jersey on July 15, 2015 for treatments occurring on or after August 1, 2015.

5. **What states does this model impact?**

   This prior authorization model impacts the states of Illinois, Michigan, and New Jersey based on where the service is rendered.

6. **Why did CMS choose these three states?**

   Illinois, Michigan, and New Jersey were selected for initial implementation of this model because of their high utilization and improper payment rates. Beneficiaries in these states had the highest average sessions by total expenditures.

7. **What conditions are covered under this model?**

   The six conditions available for prior authorization are:

- preparation and preservation of compromised skin grafts (not for primary management of wounds);
- chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management;
- osteoradionecrosis as an adjunct to conventional treatment;
- soft tissue radionecrosis as an adjunct to conventional treatment;
- actinomycrosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; and,
- diabetic wounds of the lower extremities in patients who meet the following three criteria:
    - patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes;
    - patient has a wound classified as Wagner grade III or higher; and
    - patient has failed an adequate course of wound therapy as defined in the National Coverage Determinations.

8. One of the conditions for Hyperbaric Oxygen Therapy for diabetic wounds of the lower extremities is that the wound must be a Wagner Grade III or higher. What definition will the Medicare Administrative Contractors (MACs) use for Wagner Grade classifications?

The MACs are using the following definitions for Wagner Grade classifications:

- Grade 0- no open lesion
- Grade 1- superficial ulcer without penetration to deeper layers
- Grade 2- ulcer penetrates to the tendon or capsule
- Grade 3- lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths.
- Grade 4- wet or dry gangrene in the toes or forefront
- Grade 5- gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated

9. Under prior authorization, how long will Medicare have to affirm or non-affirm a prior authorization request?

Medicare will make every effort to postmark a decision on a prior authorization request within 10 business days for an initial request and 20 business days for a resubmitted request.

10. Is the 10-day review period under prior authorization calendar days or business days?

The 10-day review period is business days. Medicare Administrative Contractors will make every attempt to review initial prior authorization requests in 10 business days and resubmitted prior authorization requests in 20 business days.

11. What is a resubmitted request?

A resubmitted request is a request resubmitted with additional documentation after the initial prior authorization request was non-affirmed.

12. Will there be a tracking number for each prior authorization decision?

Yes, Medicare Administrative Contractors will list the prior authorization tracking number on the decision notice. This tracking number must be submitted on the claim.

13. Where on the claim should the unique tracking number be populated?

When submitting an electronic 837 institutional claim, the unique tracking number (UTN) should be submitted at the 2300 – Claim Information level in the Prior Authorization reference (REF) segment where REF01 = "G1" qualifier and REF02 = UTN.

When submitting a paper CMS 1450 claim form, the UTN should be submitted in Form Locator 63. The UTN should be submitted on the same line (A, B, C) that Medicare is shown in Form Locator 50 (Payer Line A, B, C). The UTN should begin in position 1 of Form Locator 63.

14. Is there a way to expedite the payment of a claim under prior authorization?

In most circumstances, a claim that has been prior authorized will not be stopped for prepayment review and therefore not subject to any delay. However, normal claims processing timeframes still apply, which require that Medicare Administrative Contractors wait a minimum numbers of days before issuing payment.

15. Will these claims still be subject to additional post pay review?

Generally, the claims that have an affirmed prior authorization decision will not be subject to additional review. However, CMS contractors, including Zone Program Integrity Contractors and Medicare Administrative Contractors, may conduct targeted pre- and post-payment reviews to ensure that claims are accompanied by documentation not required during the prior authorization process. In addition, the Comprehensive Error Rate Testing contractor must review a random sample of claims for post payment review.

16. For prior authorization, who will make the decision on the prior authorization request?

Medicare Administrative Contractors will make these decisions.

17. How will CMS administer prior authorization? Is there specialized staff devoted to the program?

The prior authorization is administered by the Medicare Administrative Contractors, the same contractors that currently process claims and conduct medical review on Part B services. Clinical staff are assigned to medical review and trained to ensure consistency. In addition, we will employ private sector standards in our prior authorization program such as

responding to prior authorization requesters within 10 days of receipt of an initial prior authorization package, providing responses that are specific about missing information and giving providers an opportunity to resubmit the prior authorization package for re-review. During re-submission the contractor has 20 business days for review.

18. Will prior authorization allow for electronic submission of prior authorization requests?

Submitters who choose to utilize the prior authorization process may send prior authorization requests to the Medicare Administrative Contractors via mail, fax, or through the Electronic Submission of Medical Documentation (esMD) system. However, at this time submission through the esMD system is not available in all states. More information on esMD and availability can be found at http://www.cms.gov/esMD.

19. Why did CMS choose to test prior authorization on hyperbaric oxygen therapy for certain covered conditions?

Previous experience indicates that hyperbaric oxygen therapy has a high potential for improper payments and raises concerns about beneficiaries receiving medically unnecessary care. In calendar year 2000, an Office of Inspector General Report on hyperbaric oxygen therapy found that:

i. $14.2 million (of the $49.9 million allowed charges for outpatient hospitals and physicians) was paid in error – beneficiaries received treatments for either non-covered conditions or documentation did not adequately support hyperbaric oxygen therapy;
ii. An additional $4.9 million was paid for treatments deemed to be excessive; and
iii. Lack of testing and treatment monitoring raise quality of care concerns.

20. What part of the payment is under prior authorization?

The prior authorization decision will address the facility payment for the hyperbaric oxygen therapy service. If a facility has no prior authorization or a non-affirmed prior authorization, the associated physician claim will be subject to medical review.

21. Is prior authorization needed by both the facility and the physician?

No, prior authorization is only needed by the facility. The supervising physician does not need to request prior authorization. However, if a facility has no prior authorization or a non-affirmed prior authorization, the associated physician claim will be subject to medical review.

22. How many treatments will be allowed under prior authorization?

A provisional affirmative prior authorization decision may affirm up to 40 courses of treatment in a 12 month period. If additional sessions are needed in excess of the 40 treatments, a new prior authorization may be submitted.

23. Is prior authorization required for hyperbaric oxygen therapy for certain covered conditions?

Prior authorization for hyperbaric oxygen therapy for certain covered conditions is voluntary; however, if the facility elects not to submit a prior authorization request, the claim related to the hyperbaric oxygen therapy will be subject to a pre-payment medical review.

24. What providers are impacted by the model?

Facilities with type of bill 13 (hospital outpatient) rendering hyperbaric oxygen therapy for one of the six conditions in the states of Illinois, Michigan and New Jersey are included in the model. In addition, the facility must be under the Medicare Administrative Contractor (MAC) Jurisdiction of JL (New Jersey and Novitas), J6 (Illinois and NGS) and J8 (Michigan and WPS). Facilities in any of the states serviced by another MAC or another jurisdiction are not included in the model. For example, a facility in Illinois who is serviced by WPS under the J5 MAC jurisdiction would not be included in the model.

25. Is a facility located in Michigan but serviced by NGS included in this model?

No, this facility is not included in the model and should not request prior authorization.

26. Are critical access hospitals included in this model?

No, critical access hospitals are not included in this model and should not request prior authorization.

27. Is there a specific form to use?

The Medicare Administrative Contractors participating in the model have each developed a form to help assist submitters with prior authorization requests. Submitters are encouraged to use the form, but it is not required. The form can be downloaded from your Medicare Administrative Contractor's website.

28. Should the ordering physician or supervising physician be listed on the prior authorization request?

The ordering physician should be listed on the prior authorization request.

29. Are facilities under review by a Zone Program Integrity Contractor (ZPIC) eligible to submit prior authorization requests?

No, facilities under review by a ZPIC for hyperbaric oxygen therapy are not eligible to submit prior authorization requests.

30. Is prior authorization needed for patients in Michigan already receiving hyperbaric oxygen therapy before April 13, 2015?

Any patient receiving therapy in Michigan with one of the included conditions on or after April 13, 2015 will be subject to prior authorization. It is recommended that prior authorization for these current patients be requested prior to April 13, 2015. Requests may be submitted starting on March 1, 2015.

31. Is prior authorization needed for patients in Illinois or New Jersey already receiving hyperbaric oxygen therapy before August 1, 2015?

Any patient receiving therapy in Illinois or New Jersey with one of the included conditions on or after August 1, 2015 will be subject to prior authorization. It is recommended that prior authorization for these current patients be requested prior to August 1, 2015. Requests may be submitted starting on July 15, 2015.

32. What if my patient needs to start treatment immediately?

Prior authorization affirmations will apply retroactively to the start date listed on the prior authorization request. Prior authorization should be requested as soon as the hyperbaric oxygen therapy is scheduled. Treatment should not be delayed due to a pending prior authorization decision. However, claims should not be submitted until the prior authorization decision has been received.

33. Will the facility be penalized if they perform the hyperbaric oxygen treatment before they receive the prior authorization decision?

Claims that are submitted before receiving the prior authorization decision will be stopped for pre-payment review. It is recommended that the claim not be submitted until the prior authorization decision has been received.

34. What are my options if I receive a non-affirmed decision?

The decision letter will specify why your prior authorization request was non-affirmed. You can correct the deficiencies and resubmit with a new coversheet and relevant documentation. If you do not wish to resubmit the request, you can submit claims with the unique tracking number identified on the non-affirmed decision letter. The claims will be denied and you can appeal the denial.

35. Where can I find more information related to prior authorization?

More information can be found at http://go.cms.gov/PAHBO.

36. Where can I send additional questions?

Additional questions on the prior authorization model can be sent to CMS at HBOPA@cms.hhs.gov.